Chapter 10: Health Care Quality and Need

Refined Quality Measures

Continuing refinements in measurement methodologies, combined with the growing availability of more detailed administrative databases, have brought a new dimension of precision to the issue of quality in health care. No longer a subjective, "physician-only, peer review" matter, quality has become a legitimate planning consideration.[1]

CARES Market Plans were required to address the impact that a proposed planning initiative solution would have on the quality of health care services provided to veterans. CARES focused on the impact of the following six aspects of quality that might result from a decision to realign services, close a facility, consolidate programs, change missions or add new sites of care.

Quality performance indicators	Access to health care services
Continuity and coordination of care	Mix of services
Volume as it relates to proficiencies	Capacity needs

Although quality is generally thought of as being measured at the clinical service-delivery level, changes in capital assets to meet changing workload demands can also impact the quality of care provided. Small Facilities Planning Initiatives examined quality from a clinically oriented perspective evaluating whether small facilities should operate under a more limited scope of practice referring more complex cases to other VA medical centers or to the community. Proximity Planning Initiatives identified clinical consolidations that could improve the volume of services or expertise available within a particular VISN or market.

Impact of CARES Market Plans on Health Care Quality and Need

Markets sometimes selected solutions that were not the most cost effective alternative for well-founded reasons, but in no cases did they select an alternative that had a less than desirable impact on quality without including a plan for elimination of that impact. One consistent theme found in these narratives was the demonstration that quality is higher in VHA facilities than in community facilities as demonstrated by JCAHO accreditation, National Committee on Quality Assurance (NCQA) scores and VHA performance measure results. This drove decisions to provide services in-house rather than to contract out. When contracting out was selected, strengthening contract oversight or enhancing case management programs was generally always proposed to minimize any impact on quality.

[1] NEJM, Quality of Care – What is it? Volume 335:891-894, Sept. 19, 1996

Performance indicators, however, were only one of the CARES quality criteria. CARES also looked at quality across five other different aspects: coordination, volume, access, mix of services, and capacity needs of health care services. The general impact of each type of planning initiative on the six aspects of quality is summarized in the table below.

Table 10.1 Health Care Quality and Need Improvements From Market Plan Solutions

Planning Initiatives	Improve Performance Indicators	Improve Continuity/ Coordinatation	Increase Workload Volume	Improve Veteran Access	Expand Service Mix	Meet Capacity Needs
Access		X		X		
Capacity	X	X	X	X	X	X
Small Facility	X		X			
Consolidations/Realignments			X	X		
Special Disabilities			X	X		X
Collaborations			X	X		
Vacant Space				X	X	X

Quality and Access to Primary Care, Acute Hospital and Tertiary Care Services

Markets with access planning initiatives for primary, acute hospital or tertiary care services were required to propose new access sites to improve the number of enrollees within driving time guidelines. Improvements in access resulting from the National CARES Plan strategy are discussed in Chapter 4, "Enhancing Access to Health Care Services." New access sites were proposed using various combinations of leases, contracts, joint ventures, and VA staffed and non-VA staffed alternatives. While cost was a factor used by markets to determine their preferred alternative, quality issues such as the ability to provide sufficient volume, mix of services or availability of health care professionals weighed heavily in their decisions.

Quality and Workload Capacity Solutions

Quality Performance Indicators

The main quality factor discussed in inpatient and outpatient capacity planning initiative narratives was the strong desire to maintain a high level of quality care as measured by patient satisfaction, clinical performance an preventive care measures and waiting times. Facilities felt strongly about achieving compliance with these VHA priority performance goals and chose an option that maintained quality or minimized the negative impact on their outcomes, whether that solution was provided at the parent facility, off- site or through non-VA providers.

Continuity and Coordination of Care

Many inpatient and outpatient capacity planning initiative solutions, particularly outpatient primary care and mental health, involved off-site care though either new access sites or expansion of existing sites. The decision to use VA versus non-VA providers was often based on data that VA providers have more control over quality outcomes through the administration of clinical guidelines and prevention measures. Many markets chose solutions that maintained the current character of their primary care group practice models to ensure a consistently high level of quality care for all

enrolled veterans. Those who chose non-VA provider solutions for positive financial or access impact also felt strongly about compliance with these measures and proposed to minimize the potential negative impact on quality by strengthening contractual oversight of quality outcomes or by enhancing case management programs to ensure coordination and continuity of care.

Volume of Service Provided

Solutions to outpatient specialty and acute inpatient capacity planning initiatives showed a greater concern for quality based on volume of care. In the case of outpatient specialty care, markets often proposed moving more primary care off-site to allow expansion of specialty care at the parent facility. The reasons most often stated for this strategy were the availability of sub-specialist providers, minimizing negative impact on affiliations due to volume of care, and proximity to diagnostic and therapeutic services. Solutions for off-site specialty care usually involved moving only selected subspecialties to Community Based Outpatient Clinics or using non-VA providers. In the case of inpatient medicine and surgery, non-VA providers were often chosen as the preferred solution because the impact on quality due to low volume of care was perceived to be more important than the impact on quality due to fragmentation of care among multiple providers. Consolidation of acute programs within a market, and other realignments for reasons of quality, cost and staffing efficiencies, were often seen in acute inpatient psychiatry.

Access to Care

Both VA and non-VA solutions seek to have a positive impact on quality by improving access and reducing waiting times. This was stressed most often in outpatient specialty and mental health planning initiatives. Specialty care waiting times have been a focus of VHA over the past few years. For outpatient mental health, integration into a patient's community was viewed as having a significant impact on quality due to increased compliance with treatment plans and decreased potential for hospitalization.

Mix of Services

Many markets chose to establish new or to expand existing Community Based Outpatient Clinics or Satellite Outpatient Clinics (SOPs) to include primary, mental health, specialty and ancillary/diagnostic care. These markets provide models using this expanded mix of services to improve quality by decreasing waiting times, reducing duplicated tests and repeat visits, and increasing patient satisfaction. Markets that did not have the population base to support these larger CBOCs or SOPs generally felt that quality of care, based on these same factors, would be greatest if provided at the parent facility where patients would have access to specialized and support services.

Capacity Needs

Market Plans were required to resolve capacity needs in workload and space. Controls were in place to ensure that the plans did resolve these gaps in the IBM Market Planning Template.

Quality and Small Facilities

The majority of medical centers that proposed closing acute hospital beds planned to refer workload to other VHA facilities and to community hospitals in order to keep access local, maintain customer satisfaction and improve cost efficiencies. The impact on all aspects of quality was considered positive. The medical centers that proposed to retain less than 40 acute hospital beds indicated that the potential impact on quality from low volume would be offset by such factors as being a key provider in the community or vast distances to other VHA facilities. A proposed solution for minimizing the impact of low volume on quality involves a conversion of acute beds to a Critical Access Hospital (CAH). Medicare's CAH criteria includes such provisions as being part of a referral hospital network, length of stays no more than 96 hours, full-time emergency coverage, and designation by the state as a 'necessary provider.[2]

Quality and Proximity/Campus Realignments

No consolidation or realignment proposals resulting from proximity planning initiatives are anticipated to have a negative impact on quality. Quality issues resulting from proposed realignments were discussed in the narratives in terms of the impact on medical school affiliations, DoD sharing agreements and veteran access. Consolidation of services, particularly small volume and high cost procedures and subspecialties, was viewed as having a positive impact on quality of services provided.

Quality and Special Disability Programs

Spinal Cord Injury and Disorders and Blind Rehabilitation planning initiative solutions focused on quality in terms of expanding capacity and improving access to meet veteran needs through 2022. Some facilities propose space enhancements to improve the quality of the environment in which these services are provided.

Quality and Collaborative Opportunities

Quality was often stated as a positive impact of DoD collaborative initiatives, generally based on volume and mix of services. DoD physicians that are given clinical privileges at a VHA facility enhance care to veterans and maintain their proficiency for small volume procedures. DoD has more extensive experience with the treatment of women and children and offers patient care and resident training expertise in these specialties.

Quality and Vacant Space

CARES Market Plan vacant space solutions largely impacted cost efficiency and environmental safety, with a lesser impact on health care services and need. Vacant space was converted or reserved for future health care services when demand data supported the need. Buildings determined to be unsafe or unusable buildings too costly to maintain were proposed for demolition. Usable buildings not needed for future health care services were proposed for enhanced use lease, out-leasing, collaborative efforts or other alternatives that would avoid cost or produce revenue. Some of the enhanced use lease solutions would improve access and service mix by providing veterans with additional services, such as independent living and assisted living.

[2] Chapter 8 "Strategic Direction of Small Facilities" and Appendix N "Critical Access Hospital Designation"